NH MEDICAL CONTROL BOARD

Androscoggin Valley Hospital
Berlin, NH

MINUTES OF MEETING

July 20, 2006

Members Present:	Donavon Albertson, MD; Tom D'Aprix, MD, Frank Hubbell, DO; Jim Martin, MD; Joseph Mastromarino, MD; Douglas McVicar, MD; Norman Yanofsky, MD; Sue Prentiss, Bureau Chief;
Members Absent:	Chris Fore, MD; Jeff Johnson, MD; Patrick Lanzetta, MD; Joseph Sabato, MD; William Siegart, DO; John Sutton, MD;
Guests:	Dave Dubey, Jonathan Dubey, Janet Houston, Jeanne Erickson, Michael Pepin; Steven Jones; Chad Miller; Kathleen Damonico;
Bureau Staff:	Vicki Blanchard, ALS Coordinator, Kathy Doolan, Field Services Coordinator; Clay Odell, Trauma Coordinator; Fred von Recklinghausen, Research Coordinator

I. CALL TO ORDER

Item 1. McVicar called the meeting of the NH Medical Control Board (MCB) to order at the Androscoggin Valley Hospital in Berlin, NH, on 20 July 2006 at 0900.

Introductions were conducted.

II. ACCEPTANCE OF MINUTES

Item 1. May 18 Minutes were previously approved via the email procedure established in March 2005.

III. DISCUSSION AND ACTION PROJECTS

Item 1. Message from Frank Hubbell: Hubbell announced that Peter Hayes, who has been involved in EMS since the 1960's, and done extensive teaching, most recently promoting best practices for vehicle extrication, has been fighting metastatic cancer. Peter has recently received treatment for an esophageal tumor, and is now moving ahead with chemotherapy. The board expressed warm best wishes for Peter. A card was circulated for all to sign.

Item 2. ACLS 2005 Standards:

Subcommittee Report: Blanchard and J Martin presented the Protocol Subcommittee's recommendation for incorporating the 2005 AHA Guidelines into the 2007 Protocols. The subcommittee suggested changing the Patient Care Protocol where it referenced Circulation to add performance of …"cardiopulmonary resuscitation in accordance with current guidelines as *trained and credentialed…"*

The subcommittee's feeling was that not all providers would be upgraded to the 2005 Guidelines by January 2007, especially in light of the fact that the BLS training did not officially begin until 01 July 2006; the ACLS material will not be available until August and PALS material will not be available until the fall.

The subcommittee believes there will be a transition period and did not want providers to feel they were violating protocol because they had not received the updated training.

Discussion: D'Aprix stated that we could mandate an update to 2005 standards by January 2007, but felt it could be burdensome. J Martin stated that the teaching materials for the 2005 AHA guidelines just came out this summer.

McVicar pointed out that the 2007 Protocols will be in effect until 2009.

Prentiss stated that she didn't feel the implementation of the 2005 standards should be allowed to lag too long. Although she understands that some difficulty might result from requiring 2005 standards by 2007, she also could foresee difficulties if they were not implemented until 2009.

Yanofsky and Albertson voiced the opinion that it was not really a big deal, as the changes in AHA 2005 are marginal and not a matter of life and death. Besides, as services upgraded their equipment (AEDs), so too providers will automatically be trained in the new guidelines when they do their recerts.

McVicar said he was willing to allow the providers to upgrade at their next scheduled recert, but he felt that felt it was very important that the 2007 protocols reflect all the changes made in AHA 2005. Otherwise, by 2008 when providers will all be recertified to 2005 standards, the protocols – which would be in conflict with AHA guidelines – will be holding the providers back from following the new guidelines.

Decision: A motion was made that "1. The protocols will be brought into compliance with the AHA 2005 guidelines, and 2. Providers will perform CPR and ACLS as trained and credentialed." (This motion was presented with the understanding that providers are expected to update their certifications to be current with the most recent AHA guidelines as per their expiration dates and licensing requirements.) Approved unanimously.

Subcommittee Report: After the discussion on AHA 2005, the subcommittee's proposed Adult and Pediatric Cardiac Arrest protocols were presented.

For the Adult Cardiac Arrest the notable changes included:

- Listing out the medication regime for the Intermediate.
- Removed the IO route of medication from Intermediates
- Made note that IV medication route preferred over ETT
- Under Paramedic's order instead of listing out every algorithm, the statement, *"Follow ACLS Guidelines as trained and credentialed"* was added.
- Post-resuscitation pressor medications will require an infusion pump.
- Nasogastric or orogastric tube to decompress the stomach of an intubated patient.

For the Pediatric Cardiac Arrest protocol the notable changes included:

- Adding the statement *"Follow PALS Guidelines as trained and credentialed."*
- Listing out the medication regime under the Paramedic orders, realizing that not all paramedics would have PALS.
- See more discussion of PALS under Item 5 below.

J Martin commented that the requirement of an infusion pump for certain medications is not any kind of mandate. If a squad chooses to use certain medications, then patient safety requires that they have a pump. If they don't want to buy pump, they don't have to use those medications. McVicar and Prentiss agreed that this sort of protocol does not constitute a mandate.

Item 2: Immunization Program: Prentiss pointed out the copy of the Immunization Program in each board member's meeting packet. She explained that Blanchard had assembled this program after the board approved the prerequisite at the May 2006 meeting. The program represents a complete prerequisite package, and will serve as a model for future prerequisites.

Prentiss explained this particular program will train paramedics for immunization clinics. Training must be done by nurses and physicians. There is a Train-the-Trainer for nurses and physicians planned for August 29, 2006 13:00 – 15:00, which will be held at the Police Standards and Training Academy in Concord, and beamed out to Littleton, Keene, Portsmouth, and possibly to the Technical College in Berlin.

Item 3: Prehospital Heparin. Mastromarino handed out an updated Acute Coronary Syndrome protocol which included heparin administration in collaboration with medical control.

Members identified and corrected typographical errors. McVicar asked if the fibrinolytic checklist was part of the protocol. Mastromarino replied that it is included in the last five lines. He suggested that the fibrinolytic checklist be moved from the paramedic orders up to the basic. The protocol was amended to make this move.

Albertson asked how the cath lab was activated, and Mastromarino answered the Emergency Department (ED) did it. The ED would generally be aware of the incoming patient because it would receive the EKG in most cases. Since the medics themselves were not contacting or activating the cath lab, the instruction "Contact receiving facility and activate the cath lab" was amended to simply "Contact the receiving facility."

Decision: Albertson moved to approve the ACS protocol as amended, and Yanofsky 2nd the motion. Vote: passed unanimously.

Item 4: Intermediate Intubation:

Question presented: 1. Blanchard asked the board to review the Adult Airway Matrix approved at the November 2005 MCB meeting. Is this what the MCB wants for the 2007 Protocols? 2. Also, she asked that the board amend the matrix to add the sentence, "*EMT-Basics and EMT-Intermediates are authorized to use adult advanced airways only for patients in cardiac arrest "*

Discussion: Prentiss stated she knew that the board and the protocols subcommittee were leaning against EMT-I endotracheal intubation. However, she reminded the board that a sort of compromise was possible, in which Intubation Prerequisites could be developed and more data could be collected over the next year

Yanofsky asked how many EMT-Intermediates are part of programs approved for intubation. Prentiss replied that about 100 services around the state have programs. These squads are continuing this modality under waivers for the rest of 2006.

McVicar wanted to know the data to date on EMT-Intermediate intubation. Von Recklinghausen reported that since May there were 16 intermediate intubations and of these 6 were successful.

D'Aprix stated that the majority of the protocol subcommittee supported the AHA recommendation that with the advent of new airway devices it is not always necessary to intubate a patient and he would move to remove intubation from the intermediates skill set.

J Martin agreed with D'Aprix.

Hubbell stated that what is mostly needed is aggressive airway education across the board. He felt the training out there was weak and needed improvement. Much more time must be devoted to airway skills in training and recertification.

McVicar agreed that with the advent of the newer airways more time is needed for practicing with those airways, and not watered down with ETT.

Yanofsky felt that the intubation program as we know it is not successful and should be stopped.

Prentiss again raised the possibility of putting prerequisites on the skill. Albertson stated that even with prerequisites, the one most effective prerequisite would be one requiring OR practice intubations. However, since the resources are just not there for OR intubations, prerequisites are not really a practical solution.

J Martin stated it is important to point out to the providers that it is not so much that we are taking away a skill as much as we are advocating the use of difference advanced airways. McVicar agreed that the situation here is technology that is changing, and NH is moving forward with these new airways.

J Erickson, speaking for the "voices of the wilderness", stated that although she did not have any statistics to back her up, she knew people were going to be very disappointed. She asked that the board emphasize that it is a national trend of changing technology, AHA recommendations, and journal studies that are moving us down this path to better patient care, and that this is a proactive movement.

Decision: D'Aprix moved that the board amend the protocols and the Adult Airway Matrix to strike ETT at the EMT-Intermediate level, and to add the sentenced "*EMT-Basics and EMT-Intermediates are authorized to use adult advanced airways only for patients in cardiac arrest.*" This decision to become effective January 1, 2007. Hubbell 2nd.
Vote: Unanimously approved.

Item 4: Protocol Formatting: Hubbell apologized for not having sample formatting drafts available for review. His publishing firm has received 8 national awards over the past few months, and has been consequently quite pre-occupied.

Hubbell did have a sample document showing formatting using colors and font changes. He asked if the board would like him to continue to pursue the reformatting of the protocols or who they like to look elsewhere?

The board agreed that they would like to see Hubbell's group continue to work on some formatting samples.

McVicar asked if this service would be provided free, as a donation to NH EMS. Hubbell stated that his intention was definitely to do this as a free service.

It was asked if the document could be formatted to be not only color, but also in graytone for those who could not afford to print colored documents. Hubbell replied, yes there was a technique in which stippling can be applied for graytone.

J Martin asked if the they would not only format coloring and font sizing, but also indentations. Again, Hubbell stated yes.

D'Aprix referenced the Virginia protocols that Blanchard had emailed out earlier this month as a sample. It had a mix of written protocols, along with flowcharts. D'Aprix noted that every provider he showed them to liked the document. D'Aprix thought perhaps for the 2009 version we could consider this type of mixed formatting. The document would be large, but since it is an electronic document, size might not be a major issue.

Decision: D'Aprix moved that we accept Hubbell's offer to format the 2007 Protocols. J Martin 2nd. Vote unanimously approved.

The board took a short break.

Item 5: Protocol Revision Update

MCI/Hazardous Materials protocol divided into two separate protocols:

- Hazmat: added pediatric and special requirement population decontamination guidelines (elderly/frail, some special needs, and some patient with medical appliances)
- MCI: Triage tag colors added to triage categories
- MCI: "Black" category formerly "expectant", is now – per New England Council – "dead" only. ***Decision:*** MCB approved protocol subcommittee language which allows non-dead, but very likely to die, to be triaged black, notwithstanding the New England Council.

Interfacility Transfer protocols:

- The Interfacility Transfer protocols are nearly completed. A special working group, the Interfacility Committee, has been working on these under the leadership of Clay Odell. They are currently scrutinizing and adopting the new NHTSA transfer guidelines including definitions of "Stable" and "Unstable" patients.

Rehabilitation

- Still under review. What the protocol subcommittee wants are clear guidelines for the providers and at this time no one has been able to come up with any national standards. Hubbell feels this is a very important issue as nationally 60% of fire fighter line-of-duty deaths are cardiovascular, rather than due to burns, trauma, toxins or smoke inhalation, as some might think. Locally the issue is very controversial. It seems to be in some ways a matter of Fire Service SOP, more than medical protocols, unless EMS has been asked to screen fire-fighters.
- It is the protocol subcommittee's request at this time to go to the Coordinating Board and ask for help in bringing fire and EMS together to work on this. ***Decision:*** The MCB will turn this issue over to the Coordinating Board, which has a provider-safety subcommittee. We will standby to offer any technical assistance the Coordinating Board requests. The MCB will

research evidence-based standards for a protocol. Frank Hubbell will look at military data, and Mike Pepin will seek data from NFPA. Mike Pepin, who is a member of both the Coordinating Board and the Protocols Subcommittee, will present this issue to the Coordinating Board this afternoon. If CB discussion indicates that such a protocol would find use in any setting, we will develop one.

Seizure Protocol

- Diastat (Diazepam Rectal Gel): The board was asked to consider whether EMT-Basics should be assisting parents in the administration of Diastat for pediatric seizures. ***Decision:*** The board felt that Diastat should never be administered by the EMT-B, and also should not be an assisted skill. However, the protocol should mention the medication, perhaps in a box., for purposes of awareness. (e.g. "Be aware that patient with known seizures may have Diastat or VNS . . .")
- Vagus Nerve Stimulators (VNS): Under the Basic orders the VNS will be mentioned for purposes of awareness. (see above)

Central Line Catheters

- Should paramedics be able to access indwelling IV lines? Discussion covered the potential dangers of air embolism, infection, contamination, damage to the line, and the high emotional for the patient if re-insertion is needed. There is also a difference between types of lines. IV lines are started in field for a spectrum of urgency ranging from prophylactically with no intention to give fluids or meds, to lifesaving intervention.
- Accessing these lines would also require special training, which would need to meet the approval from the MCB and NH Bureau of EMS.
- ***Decision:*** The board agreed that in the case of previously existing central line with an external port (PICC line, Groshong, Hickman) a paramedic may access the line if there is a clear indication for immediate use. However they may not access the line for prophylactic reasons. The board agreed that subcutaneous ports (Mediports, Port-a-caths) could not be accessed by a paramedic. However if the port is already accessed, the paramedic may use the line if there is a clear indication for immediate use.

Pediatric Advanced Life Support Course

- Should the MCB require paramedics to pass a PALS course? This issue was discussed about a year ago, and the MCB decided to not require the PALS course. D'Aprix reported that the protocols subcommittee has been discussing this issue again, and decided to raise the question with the MCB. Houston stated that since our last discussion the Institute of Medicine has issued a report on Children. They recommend that licensing agencies define and ensure competencies for pediatric care; but they do not actually recommend PALS, APLS, PEPP or any specific course.
- ***Decision:*** The MCB did not approve the requirement that paramedics pass a PALS course. PALS guidelines can be incorporated into protocols. The question of whether demonstration of competencies should be defined for re-licensure is referred to the Coordinating Board.

Pediatric Consents

- Albertson raised the question of whether treatment for behavioral conditions, including substance abuse, could be provided without parental consent at age 12. Discussants noted that there may be NH statute that determines this. Care for Sexually Transmitted Diseases and pregnancy may have similar statutory consent provisions. A few years a ago a legal review of consent-to-treat law in NH by John Stephen led him to conclude that the issue was too complex to be reduced to protocol.
- ***Decision:*** Any legal definition of age for behavioral or emotional pediatric patients should be removed from protocol. The MCB would like to see the statutes that define ages of consent-for-treatment, and would consider providing them, perhaps in a box, for EMT awareness. (see discussion above *re* awareness information vs. protocol.)

IV. INCUBATING PROJECTS & SUBCOMMITTEE REPORTS

ACEP: No report.

Bureau and Division Update: Printed report was distributed to all members. See attached.

Intersections Project: : No report.

NH Trauma System: No report .

TEMSIS: No report

V. ADJOURNMENT

Motion by Hubbell, seconded by Mastromarino to adjourn. Approved. Meeting adjourned at 12:15.

VI. NEXT MEETING

September 21, 2006 at the Monadnock Community Hospital, Peterborough, NH.

Respectfully Submitted,

Suzanne M. Prentiss, Bureau Chief, EMS

(Prepared by Vicki Blanchard, ALS Coordinator)